DEPARTMENT OF HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CHILDREN'S HEALTH INSURANCE PROGRAM

MARGARET A. MURRAY, DIRECTOR

MICHELLE WALSKY, NJ KIDCARE, DIRECTOR

TABLE OF CONTENTS

OVERVIEW

QUARTERLY REPORTS

A. EXPENDITURE REPORTS

B. FINANCIAL / STATISTICAL REPORTING

ANNUAL REPORTS

STATE PLAN OPERATIONS INFORMATION

A. ELIGIBILITY STANDARDS AND METHODOLOGY

B. NJ BASELINE METHODOLOGY OF UNINSURED CHILDREN

C. OUTREACH EFFORTS

D. PROGRAM MONITORING

Quality of Care Standards

E. REDUCING THE BARRIERS

F. OBJECTIVES AND PERFORMANCE GOALS

PROGRAM INDICATOR DATA

A. CROWD OUT INDICATORS

B. OUTREACH INDICATORS

CONCLUSION

APPENDICES

Overview

Governor Christine Todd Whitman signed the NJ KidCare program into law on December 23, 1997, with an effective date of January 1, 1998. The program presented New Jersey with a challenging and exciting opportunity to address the health care needs of its greatest investment, its children. NJ KidCare began the challenge of offering quality health care to approximately 102,000 uninsured children under the age of 19 years on February 1, 1998.

NJ KidCare, in meeting the challenge, created a comprehensive and affordable program with three distinct plans that prescribes to the principle that all children deserve health insurance and the opportunity to receive quality health care. The three plans, Plans A, B, and C, which provides coverage up to 200 percent of the federal poverty level (FPL) further demonstrates that principle. By developing three distinct plans, New Jersey was able to make available health insurance to a larger proportion of uninsured children.

Plan A, is an expansion of Medicaid services that covers children whose family income does not exceed 133 percent of the federal poverty level. Children will receive the same benefit package as the current Medicaid population. Plan B will be based on family income that does not exceed 150 percent of the federal poverty level (FPL). For Plan C, 151 to 200 percent of the federal poverty level will be used to determine financial eligibility. Plan's B and C will offer eligible children a modified, managed care benefit package. Plan C will require a $15 premium contribution per family and copayments for some services.

NJ KidCare realized how important outreach efforts would be in achieving the highest enrollment possible and sought to design and implement strategies that reflected both conventional and new methods. The strategies focused on overcoming known barriers for successful enrollments. To date, we have approximately 26,000 children enrolled. NJ KidCare used a persistent and multi-pronged outreach approach that included mass mailings, targeted mailings, targeted telephone contacts, statewide presentations, and developing partnerships with the public and private sectors.

The program's media campaign was unique in that it was designed using input from three specially convened focus groups of targeted families. The resulting "message" was delivered utilizing public service announcements, newspapers, billboards and radio. Other outreach methods involved the coordination of public and private entities, included the use of taxation and motor vehicle databases and movie screen advertisements. Although these methods have had results, we continue to monitor the efforts as part of out dynamic evolving plan that will target the hard to reach uninsured child.

The future of NJ KidCare envisions the provision of quality health care to every uninsured child in New Jersey through changes to or enhancements to existing processes and the implementation of Plan D. Effective July 1, 1999, Plan D will provide coverage to children with family incomes up to 350% of the FPL. It is expected that this plan will benefit approximately 60,000 uninsured children and target the working family with an income up to $57,575 for a family of four. Plan D will use the same infrastructure currently in use for NJ KidCare. Health care services under Plan D will 1) be based on a commercial package, 2) be provided through existing managed care plans, and 3) require a premium based on a sliding fee schedule.

Quarterly Expenditure Report

The Administrative and Financial Services Office submitted the CHIP (NJ KidCare) first quarterly expenditure report to the Health Care Financing Administration on December 30, 1998. This report includes expenditures from February 1, 1998, through September 30, 1998. Total reported program expenditures were $5,447,903. This amount included capitation payments and payments for services accessed through fee for service such as outpatient hospital services, physician/surgical services, prescribed drugs, clinic services and laboratory/radiological services. The majority of the expenditures ($4,523,483) are attributable to Title XIX (Plan A) Medicaid expansion beneficiaries. Also included are administrative costs ($544,793) within the 10 % limit for Title XXI administrative activities.

The first quarter expenditure (December 31,1998) report of 1999 was not completed for submission in this annual report. It will be electronically submitted to HCFA in the near future.

The quarterly reports contained within this section are as listed below:

Summary Sheet

Title XXI Expenditures for quarter ending September 30, 1998

Prior Period Adjustments

Allocation of Title XIX and XXI Expenditures

Calculation of 10% Limit for Administrative Costs

Total

Eligibility Standards and Methodology

For children residing in New Jersey in families with income at or below 133% of the federal poverty limit, coverage is available under the Medicaid program (NJ KidCare Plan A). Household income is defined as the gross income, earned and unearned, that is available to the eligible unit, less deductions and disregards as described below. The eligible unit is comprised of natural or adoptive parent(s), stepparents (optional if no common child), and all blood-related or adoptive brothers and/or sisters living in the household.

In determining family income, the following deductions and disregards apply:

- For self-employed, deduct the cost of producing income;

- From gross earnings deduct the first $90.00 per month of such earnings for each employed individual in the eligible family (including income of a child under the age of 21 who is not a full-time student) to cover work-related expenses including, but not limited to, transportation and mandatory payroll deductions;

- From the remaining earned income, deduct an amount equal to the actual expenditures for child care or for care of an incapacitated individual living in the same home as the eligible child when specific circumstances are met. In no event shall this deduction exceed the limits as follows:

    - $175.00 per month, per child age two or older, or incapacitated adult, for full-time employment;

    - $200.00 per month, per child under age two, for full-time employment;

    - $135.00 per month, per child age two or older, or incapacitated adult, for part-time employment;

    - $150.00 per month, per child under age two, for part-time employment;

    - $50.00 deducted from total income from child support payments.

- Total amount of monthly child support and/or alimony paid out is deducted.

Methods for evaluating family income include verification through wage stubs or documentation from the employer on company letterhead, or statement of the gross benefit amount from any governmental agency providing benefits. All earned and

unearned income received within a minimum of a four-week period must be verified and documented. However, for Plan A if the family has prior medical bills, 3 months income verification is required. On-line access is available through the Department of Labor to wage, unemployment, and disability files.

For children in families with gross income at or below 200% of the federal poverty limit (NJ KidCare Plans B and C), a modified benefit package is available, with cost sharing required for families with income above 150% of federal poverty limit (NJ KidCare Plan C). Determining whether a family meets either the 200% or 150% limit is based on a simple calculation of gross income with no deductions or disregards. Household and family income is defined as gross income of the family including the gross income of all legally responsible adults, unearned income of minor children, and with respect to dependents of persons residing in a household separate from the dependent, that portion of the legally responsible adult's income required to be available for the care and support of that dependent.

In accordance with Federal requirements, a child who meets the eligibility criteria for the expanded Medicaid program (NJ KidCare Plan A) is not be eligible if the child is covered by other health coverage. Under Medicaid, Title XIX, if a child has health insurance coverage and met all other eligibility requirements, the child would be eligible for Medicaid. The other insurance would be treated as a third party resource with Medicaid remaining payer of last resort. However, under Title XXI, if a child has health insurance coverage, the child will not be eligible for KidCare. The key differences between the two cases is that Title XXI children must be uninsured. For children living with a custodial parent or guardian, outreach will be made to the Child Support agency to determine if the child support order includes medical support.

Unlike NJ KidCare Plans B and C, under the Medicaid expansion (NJ KidCare Plan A) there is no requirement that the child be uninsured for a 12 month period. This is due to the fact that "crowd-out" (see crowd-out indicator) is less of a concern in the lower income population. In addition, it serves to lessen the disparity between the children covered under the Medicaid expansion and other Medicaid-eligible children.

A family with income greater than 133% of the federal poverty level who meets the criteria for NJ KidCare coverage under Plans B and C must be uninsured for a minimum of 12 months. The 12 month requirement will change to 6 months effective January 1, 1999, (see crowd out indicator). Exceptions are granted for children who are losing Medicaid eligibility and have no other health care coverage at the time of termination. Exceptions are made to the 12 month (changed to 6 months) requirement in certain limited circumstances (for example, prior coverage was lost because an employer went out of business or the employee was laid off), where crowd out concerns are not at issue. Also, if health coverage that is available, but which is not purchased, will not be considered in the evaluation of the applicant's eligibility for the program.

Eligibility under the Medicaid expansion (NJ KidCare Plan A) is applied back to the first day of the month of the application or as of the first day of the first month in which the

person is found eligible. Retroactive eligibility is available to cover unpaid medical bills for the three months prior to the date of application if the requirements for eligibility are met in each of the three months. (NOTE: Retroactive eligibility was not available for any period prior to the start of the program.) Initially, monthly eligibility card was issued in accordance with existing Medicaid practices, although this may change with the future application of new technology. This technology may include permanent plastic I D cards with on-line verification. During the period of time when the child is choosing and being enrolled in a specific HMO, all services are available on a fee-for-service basis. The family will be asked to select from participating HMOs covering the county in which the child resides. If no selection is made, the NJ Care 2000 default assignment rules will apply.

For Title XXI eligibles (NJ KidCare Plans B and C), a managed care approach that mirrors the commercial insurance environment is used. Under such mainstream plans, enrollment is not effective until the application process is complete and the individual is enrolled in the managed care plan. Therefore, neither presumptive eligibility nor retroactive eligibility is available. A default enrollment process is not required.

There is an exception to this process, however, for newborns. To ensure that newborns are not denied needed services, including those associated with birth, for newborns who are deemed potentially eligible based on initial screening, services is covered on a fee-for-service basis until the end of the month following the month of birth.

Families are able to choose among participating HMOs in their county of residence to provide coverage for all the children in the family. The effective date of eligibility will be the date the child is enrolled in a participating HMO. This will usually occur between 15 and 45 days of the date that eligibility for the program is determined. Children will be allowed to change plans once every 12 months, unless there is good cause.

For children eligible under the Medicaid expansion (NJ KidCare Plan A), the formal fair hearing mechanism will be available for appeals involving the eligibility determination. Since the inception of the program 4 families have appealed. For the children denied eligibility under Title XXI (NJ KidCare Plans B and C) or who are terminated for non-payment of premium, there is a mediation mechanism as the first step in the appeal process (see appendix). This can be followed by a formal appeal to DMAHS, which must be submitted in writing within 10 days of the adverse notification, regardless of whether mediation is attempted. If a formal hearing is requested, the State has outlined a process to be followed. A panel comprised of State staff, who will make recommendations to the Division Director, will hear this appeal. Within 45 days of receipt of the appeal, the DMAHS Director will issue a final agency decision, which is subject to judicial review in the Appellate Division.

The State vendor will screen all applications for potential Medicaid eligibility. Those that involve children that are members of families already receiving Title XIX benefits through the County Boards of Social Service or who appear to meet the standard for cash assistance will be sent to the County Board of Social Services for a determination. For the

remaining children with income at or below 133% of poverty, a determination will be made whether they are eligible for Medicaid and whether they would have been eligible prior to the NJ KidCare expansion. For this group (Plan A), State staff must validate all eligibility determinations done by the Vender.

To ensure that the insurance provided under Title XXI does not substitute for coverage under group health plans, outreach will be made to employers to ensure that the individual is not covered and, where applicable, that no coverage has been provided for the previous 12 months. Outreach will also be made to any employer who may be providing coverage under a COBRA option.

Outreach Summary

A successful outreach and enrollment campaign requires the involvement of providers, community-based organizations, public employees, consumer advocates, and consumers. To ensure maximum saturation and program participation, the New Jersey KidCare Plan incorporated the following critical elements in a persistent and phased scenario**:**

- The Public Process
- Targeted Outreach
- Community Training and Outreach
- Private Partnerships
- Community Relations
- Consumer Education
- Top Ten Successful Outreach Efforts
- Outreach Plan - Phase I-VIII

The Public Process

Statewide public hearings were conducted in northern, central, and southern New Jersey. A public notice appeared in all major newspapers. In addition, key stakeholders, agencies, and organizations were notified of the hearings.

The process continued with the finalization of multilingual informational materials including posters, brochures, public service announcements, press releases, letters, and notices.

Prior to and through the public process, representatives of governmental agencies were involved in the development of the outreach plan. A significant component of the public process was the development of the speakers' bureau whose main focus is to disseminate information on CHIP. The bureau included DHS county representative, the Medicaid District Offices, and the DHSS Child Health Program.

The Plan also built upon existing children outreach and education initiatives that have proven successful in reaching families:

- Maternal and Child Health Consortia
- Healthy Mothers, Healthy Babies Coalitions
- New Jersey Child Health Regional Network
- Special Child and Adult Health Services Case Management Units (1 in each county)
- School-based Youth Services Program
- Department of Health and Senior Services (DHSS) Office of Minority Health, October 1997 initiative for CBO support of immunization outreach
- Model for ministerial outreach developed by DHSS for Women, Infants and Children Program (WIC)
- New Jersey Local Information Network and Community System (NJ LINCS) - 24 local health departments, Newark, Jersey City, and Paterson
- Rutgers Cooperative Extension
- Subsidized Day Care (Division of Family Development)

Targeted Outreach

Through its various departments, the State has access to a number of data sources that provide information of a general and specific nature that were utilized to perform targeted outreach for children potentially eligible for health care coverage under both the KidCare and Medicaid expansion options:

- **National Free School Lunch Program (NFSLP) -** The Department of Education maintains information concerning public school children who participate in the NFSLP. The free program has income standards that are below 133% Federal Poverty Level (FPL), and the Reduced Price Program has standards that exceed 133% FPL. The State and the Department of Education is in the process of determining the best method for using this data base confidentiality issues.

- **The New Jersey Special Child Health Services Registry (SCHS) -** The DHSS SCHS is a comprehensive database that provides valuable information about children with congenital defects and special needs. Each year, approximately 13,000 registrations are received, and 10,000 children are entered into the database. As part of the registration process a letter is sent to the parent and to the local case management unit. The case management units serve as the

primary resource for families, providing family-centered, community-based, coordinated services.

· **Electronic Birth Certificates (EBC) -** The DHSS' Vital Statistics houses electronic birth records which are transmitted from all hospitals in the State. The record contains sufficient data to process a mailing to families with children born after February 1997. DHSS supplies labels weekly of new births for KidCare mailings. This mailing is anticipated to reach over 100,000 families.

· **Charity Care Database (Individual Hospitals) --** Individual hospitals maintain records of denied current and past recipients of Charity Care. Initial contact with several hospitals indicated interest in sharing targeted information for the purpose of direct mailing to potential eligibles.

· **Federally Qualified Health Center Expansion Program** - In 1996, between 4,500 and 5,000 children between the ages of birth through 18 years of age received services which were reimbursed as 17,251 uninsured visits. Mail KidCare applications with a cover letter to the uninsured families identified.

· **New Jersey Access and Children's First Programs**

Mailed KidCare applications to over 10,000 New Jersey Access and Children's First programs waiting list.

· **School Targeted Activities**

1a Letters to Parents-Schools gave each child, KidCare information letters, signed by the Commissioner of Education.

2a Kindergarten Registration - Provide information and applications at schools during the months that children are registered for kindergarten.

3a Provide mailers for inclusion in the material sent to families concerning the National Free School Lunch Program.

In the near future, the State plans to send a second KidCare mailing to the schools informing families of the changes in the program. For example, the increase in the income threshold from 200 % FPL to 350% of the FPL and the waiting period for families with health insurance has been reduced from 12 months to 6 months.

Community Training and Outreach

A broad-based consumer support network was established that included providers, community organizations, businesses, government field office, electronic networks, political leaders, and consumer advocates. The main function of the network is to ensure

the dissemination of informational materials to families with children who require health care coverage.

The network became an integral part of the screening and referral operations. In developing the training plan for that network, special efforts were incorporated in the plan design to ensure that: (1) efforts are coordinated with existing outreach initiatives, (2) scheduled meetings for formal organization will be utilized to maximize impact, and (3) departmental relationships and lines of authority determine responsibility for training assignments.

Private Partnerships

Developing collaborative partnerships to provide program information and educate children about NJ KidCare proved to be critical to the success of the outreach efforts in New Jersey. Partnering with associations and organizations that advocate for children has allowed for wider circulation and saturation statewide. The partnerships also provided incentives to the families of New Jersey and the partners in the form of health insurance for uninsured children. The specific partnerships and efforts provided are indicated below:

- NJ Pharmacists Association supports NJ KidCare by sending out a newsletter to all pharmacists in New Jersey. The newsletter requests that pharmacist's use KidCare "stuffers" with each prescription filled and display KidCare posters.

- Hope for Kids distributed NJ KidCare information with Christmas gifts to hundreds of children during the holidays. NJ KidCare had a very successful toy drive for this project. In April 1999, Hope for Kids, with over 1000 volunteers, will be going door to door distributing NJ KidCare information and other healthcare information.

- Southern NJ Perinatal Cooperative informs agencies in the southern region about the NJ KidCare program and how each agency can become involved. Several presentations/brainstorming sessions, initiated by this Cooperative, were held during January for various groups in the seven southern counties.

- Newark New Jersey Committee of Black Churchmen is supplying a mailing list of member churches. A cover letter under the president's signature was sent to the member churches requesting that NJ KidCare information be distributed to Sunday Schools and members of the congregation.

- United Way of Essex and North Hudson County assures that all sponsoring agencies will become enrollment sites (over 100 agencies). KidCare will assess the feasibility of assigning VISTA volunteers at the sites.

· Association for Children of New Jersey and Gateway Maternal & Child Health Consortium submitted "KidCare Enrollment Project" proposals to NJ Healthcare Foundation. The goal of the project is to enroll eligible uninsured children in NJ KidCare by targeting families with children who utilize key community health and social service organizations in the South Ward of Newark. Under the project, grants will be granted to three 3 community partners, Children's Hospital at NBIMC, Newark's Women, Infants, and Children Program, and Leaguers Head Start. An amount of $110,000 was awarded by the foundation for this project. The Office of NJ KidCare worked closely with ACNJ on this project and plans to support this effort by providing technical assistance and VISTA volunteers.

· New Jersey Hospital Association has identified CHIP as the perfect opportunity for hospitals to become community leaders by identifying and enrolling eligible uninsured children. First, by encouraging all hospitals to review it's Charity Care database and contact families who may quality for NJ KidCare. Second, submit NJ KidCare article to local newspapers especially minority papers. Third, sponsor some type of KidCare outreach effort. Finally, include articles in association's newsletters routinely showcasing hospitals that have done outreach successfully.

During the second year the State will direct its effort towards Community Relations and Customer Education. The following will give a brief outline of what each initiative will accomplish:

Community Relations

To address the ongoing need for a community information process, the initiatives to be undertaken would include:

· a mass media marketing campaign to increase public awareness of the New Jersey Medicaid Program, de-stigmatize the image of medical assistance, and highlight specific program segments;

· a comprehensive outreach program designed to promote coordination of services among stakeholders, enroll Medicaid eligibles, bring beneficiaries into care, and provide special outreach services for hard-to-reach populations; and

· a multidisciplinary consumer education program to advise beneficiaries of program policies and procedures, promote self-advocacy, empower beneficiaries to make informed and responsible decisions regarding their health care and emphasize the importance and practice of primary and preventive health care;

· development of an outreach network bridging the Medicaid, NJ KidCare Programs to the community level by establishing a network of active two-way

communication through focus groups, surveys and dialogue with beneficiaries and community organizations.

Customer Education

New Jersey, in its role as the purchaser of high quality health services, is expanding its efforts to protect and increase beneficiary satisfaction in accessing needed health care. The Beneficiary Education Program will develop and implement strategies to improve the use of services in its fee-for-service system as well as its voluntary and mandatory managed care reimbursement programs.

While being responsive to the unique health care needs of each beneficiary as well as supporting effective enrollments into the appropriate delivery system in accordance with those unique needs, the program's primary goals will be:

· to provide education, information and support in a environment conducive for successful access, navigation, and empowerment into the health care delivery system; and

· to improve the overall satisfaction of the beneficiary clientele.

TOP TEN SUCCESSFUL OUTREACH EFFORTS

OUTREACH EFFORT	BAROMETER OF SUCCESS	COMMENTS
1) SCHOOLS Department of Education partnership provided access to 4000 public school principals throughout the State of New Jersey. Outreach included a letter from Governor Whitman with an attached letter for students plus a fact sheet.	Statistical response to hot line number increased markedly in weeks post school mailings	Mailings more effective after September to avoid saturation of documents to parents.

2) SCHOOL NURSES ASSOCIATION President of School Nurses Association throughout NJ received information on NJ KidCare and has been instrumental in reaching targeted KidCare audience.	Statistical response to hotline number increased markedly in weeks post mailings to school nurse presidents.	The school nurses are an excellence source for reaching children. Attending the School Nurse Association Conference is an opportunity to dissemination of KidCare information and to gain support from the school nurses.
3) RADIO Public Service Announcements (PSAs) taped by Governor Whitman have been aired on selected radio stations where targeted KidCare audience resides. The PSA were done in English and Spanish.	Sufficient number of inquiries directly linked to the PSAs.	A positive effect is generated to potential enrollees by the appearance of high level government official. Over 1,000 inquiries to date were received.

OUTREACH EFFORT	**BAROMETER OF SUCCESS**	**COMMENTS**
4) NEWSPAPERS Display ads placed in minority newspapers and major newspapers.	Eleven percent increase in call volume requests for KidCare information.	Printed documents are believed to be a resource that prompts customers to take action after the initial reading. Newspaper

		circulation reaches a large audience.
5) WIC MAILINGS Labels from 23,000 uninsured households generated from WIC files. Enrollment packet and letters sent to each family.	Number of callers identifying the receipt of the letter generated from the WIC files.	This is opportunity to use a large established program to reach targeted population. If possible, stagger large mailings so that the call center is not overwhelmed.
6) HOSPITALS/HEALTH PROFESSIONALS Both Commissioners, Department of Human Services and the Department of Health and Senior Services send a joint letter to the CEO's of each hospital requesting their support with NJ KidCare. The State followed up with regional presentations as well as those individually requested.	Benefit to individual hospitals and KidCare. Hospitals were able to decreased Charity Care enrollments. KidCare was able to increase health care coverage to New Jersey's uninsured children.	Charity Care does not reimburse some hospitals at 100 percent. Therefore, NJ KidCare reduces that charity care liability.

OUTREACH EFFORT	BAROMETER OF SUCCESS	COMMENTS
7) CHURCHES Direct KidCare mailings to black and Hispanic churches statewide requesting their support getting the word out about the program to the congregation. Also, suggested ways to outreach, i.e., post fact sheet on church bulletin board, have KidCare Sunday and sponsor an enrollment driven activity. Based on requests, presentations on the program	Number of new KidCare enrollees can be attributed to referrals from urban churches.	NJ KidCare sought to establish a liaison with the church clergy as a leader in the community. Church clergy are a trusted authority in the community.

church affiliations (i.e., Black Churchmen Association in Essex County, NJ).		
8) KIDCARE BROCHURE AND PAMPHLET Developed an outreach plan to ensure saturation of brochures and pamphlets at sites known to the target population.	Incidence of the number of responses by telephone attributed to the brochure or pamphlet as the source referral.	In any given week, five to six percent of the calls requesting KidCare information.
9) COMMUNITY BASED ORGANIZATION Mailings and presentations to target organization dealing directly with KidCare audiences.	Increase in number of referrals from community based organization identifying uninsured children.	NJ KidCare has over 500 community-based organizations serving as enrollment sites.
10) COUNTY WELFARE AGENCIES The State expanded an existing partnership to allow for an opportunity to continue to serve New Jersey residents.	NJ KidCare statistics increase as indicated by the number of telephone calls and visits to statewide offices.	The county welfare agencies represent an entity that has provided ongoing services to this population.

Quality of Care Standards

Health Maintenance Organizations under contract to provide health care to NJ KidCare beneficiaries must meet stringent quality of care standards. The methods used to assure that the standards are being met include both internal and external monitoring. These include requirements for internal review by the establishment of and adherence to a written Quality Management Plan (QMP) (which follows the QARI guidelines), approved by the Division of Medical Assistance and Health Services (DMAHS). The

QMP must meet HCFA Guidelines and follow standards specified in the contract, including standards for provider participation. For example, HMOs are required to conduct routine medical audits of primary care physician sites and member satisfaction surveys at least annually.

Internal Quality Review

State staff monitoring activities of the HMOs include:

- Maintenance of a toll free hotline for HMO members for questions and complaints which are investigated and resolved.

- Assurance that marketing materials, member notices, newsletters, and handbooks are accurate and complete through a review and prior approval process.

- Ongoing review of provider networks to assure contract standards and requirements are met.

- Monitoring access and availability of HMO providers.

- Reviewing and analyzing HMO reports and encounter data.

- Conducting routine medical audits of care and audits of contract compliance and performance.

- Determining the need for corrective action for identified problems, developing (with the HMO) a corrective action plan and monitoring the results.

- Providing ongoing technical assistance to and a forum for open communications with the HMOs to assure a thorough understanding of contract responsibilities.

- Hosting regular meetings with HMO medical staff.

- Joint review of HMO operations with the PRO.

- Conducting formal member satisfaction studies. Consumer Assessment of Health Plans (CAHPS) is utilized.

- Continuous communication with community and advocacy groups.

- Maintaining a Quality Management Council comprised of provider and consumer advocacy representatives.

External Quality Review

External review of the HMOs' provision of quality and appropriate care is accomplished through routine medical audits and other medical administrative functions by DMAHS staff as well as independent quality studies conducted by an external quality review organization, Peer Review Organization of New Jersey (PRO).

Monitoring functions include:

- Annual evaluations of the HMOs' performance.

- Random review of medical records maintained by direct service providers for overall access to care, quality of care, identification of potential areas for quality improvement.

- Individual case reviews.

- Focused studies of specific aspects of care. HEDIS standards are used wherever appropriate.

- Joint review of HMO operations.

- Health Plan performance standards.

- Health care data analysis.

- Focus groups (which include HMO direct service providers), to review certain aspects of managed care and the impact on quality of care.

Additional Care Standards

Additional monitoring of internal and external care standards are being provided internally as well as externally that involves other State agencies.

- State medical staff conduct routine reviews of HMO compliance with EPSDT screenings and preventive services (i.e. well baby care and immunizations) provided under the plan. HMOs are required to submit formal studies on immunization rates. PRO staff conduct focused studies of preventive services.

- The Medicaid contract, also used for Title XXI coverage, include additional, specific standards for network adequacy. HMOs are granted approval to enroll beneficiaries up to a specified level of enrollment based on provider network capacity. A review of the enrollment caps and analysis of the pediatric networks has determined that the existing HMO contracts have the adequate network capabilities to serve the anticipated increase in Title XXI membership in

18 counties. In the three remaining counties, at least two plans have been approved in each county with sufficient capacity to serve both the Title XIX and the Title XXI beneficiaries.

· The Department of Human Services requires each HMO to have an internal system for monitoring quality.

· Department of Health and Senior Services, in consultation with the Department of Banking and Insurance, requires HMOs to comply with regulations that address the HMO operations and include methods for assuring the quality and appropriateness of care, granting Certificate of Authority and ensuring HMO network adequacy.

· HMOs must undergo an external quality audit every three years by an accreditation agency such as the National Committee for Quality Assurance or the Peer Review Organization (PRO) of New Jersey.

Access to care standards

To ensure that access standards are being met, ongoing monitoring occurs through regular reviews of any changes in the HMO network, ongoing contact with listed providers, review of grievance and complaint information, and as appropriate, undercover operations. Access to emergency services are also reviewed as part of the independent PRO review as well internal review of claims denials, complaints and grievances.

REDUCING BARRIERS FACING FAMILIES

The success of NJ KidCare enrollment in New Jersey is contingent on developing a program that families could easily access. This required reducing and eliminating barriers facing low income families. The State examined the reasons why the targeted population that would benefit from this program did not enroll. The chart below outlines key changes made.

BARRIERS	APPROVED CHANGES
NJ Medicaid application was 10 pages, with bureaucratic language.	The State reduced the application to 4 pages

	with easy to understand instructions and language.
Perception of "welfare" stigma associated with visiting the local Boards of Social Service / County Welfare Agency.	The State eliminated the face to face interview requirements and approved a mail in application.
It was difficult for families to receive non- emergency assistance after normal work hours.	The State implemented extended work hours on Mondays and Thursdays until 7 p.m. to assist with the application process. However, appointments are accepted on other nights until 7 p.m.
Some families require specific information outside the scope of the Medicaid District Office responsibilities, i.e., HMO enrollment and selection.	The State established a toll free number for families to access for questions on the application and HMO enrollment.
Families have established relationships with Community Based Organizations.	The KidCare program encouraged Community Based Organizations to partner with the State by becoming enrollment sites.
- Families whose primary language is not English find it difficult to access services.	The toll free number has the capability to translate over 140 languages.
Families would qualify for the program if they did not have to meet the asset test.	The State eliminated the asset test requirement for eligibility into the NJ KidCare program. NJ's goal is to foster personal responsibility, allowing families to keep their assets will promote this goal.
Public awareness of the NJ KidCare program to the targeted population that would benefit from the program.	NJ developed an aggressive marketing and outreach plan that targeted low-income families. The State is also, planning a proactive telephonic and door to door outreach campaign.

Objectives and Performance Goals

Strategic Objectives

- **Conduct an effective outreach program to ensure that individuals responsible for ensuring the health care of uninsured children are aware of the options provided in New Jersey under Title XXI.**

- **Reduce the number of uninsured children as reported in the Current Population Survey by 50%.**

- **Coordinate enrollment with Title XIX to ensure coverage for children previously eligible but not enrolled in the Medicaid program.**

- **Ensure the provision of high quality care that is sensitive to the needs of the beneficiary as evidenced by beneficiary satisfaction surveys.**

- **Provide access to a health care plan with a network adequate to meet the needs of the enrolled children.**

x

- **Ensure that enrolled children have access to primary and preventive care services, with a special emphasis on hard to reach populations such as adolescents.**

- **Ensure that available services are actually being utilized by the enrolled children.**

- **Improve health outcomes for children as measured by certain key indicators.**

Performance Goals and Measures

Effective Outreach		
· Must reach target population	· Number of enrolled children in Title XXI by age, income, race/ethnic category · Increased enrollment under Medicaid	· See Appendix · As of March 1999, there are 16,000 Medicaid eligible enrolled as a result of NJ KidCare publicity, who would not otherwise have been enrolled.
· Must be culturally appropriate	· Number of non-English speaking beneficiaries enrolled · Ratings as part of customer satisfaction surveys	· See Appendix · Families whose children are enrolled in NJ KidCare program will be included in the 1999 customer satisfaction survey.
· Must involve public health community	· Number of public health organizations that participate in the outreach program	· One hundred percent (100%) of the Federal Qualified Health Care Centers (FQHCs) have a contract with one or more of the HMOs. · One hundred seventeen (117) Women, Infant, Children (WIC) Nutrition Programs have participated in the outreach efforts and now serve as enrollment sites. · One-hundred twenty-one local health Departments participated in the outreach strategies.
· Must involve community-based organizations	· Number of CBOs that participate in the outreach program by county	· Over 500 community based organizations in New Jersey's twenty-one counties serve as enrollment sites.

Reduce Number of Uninsured		
· Enrollment	· Number of uninsured children as reported in the Current Population Survey · Number of children enrolled	· The adjusted estimates based on the 1997 CPS identified 102,000 uninsured children. · As of February 26,1999, 26,000 children are enrolled.
· Employ user friendly enrollment process	· % of applications requested that are completed and returned · Number of applications completed without error · Rating of process as part of the customer satisfaction survey · Track number of complaints regarding enrollment process	· 81% of the applications are returned completed and determined eligible. · This information is not available currently, however it will be available in the near future. · Families whose children are enrolled in NJ KidCare program will be included in the 1999 customer satisfaction survey. · During the period of May 1998-December 1998, the State received 133 complaints. Denial of eligibility was the major complaint.
Coordination with Title XIX		·
· Ensure referral and enrollment of Medicaid eligibles	· Number of individuals referred to Title XIX · Track enrollment of referrals into Title XIX	· 10% of the completed applications were referred to Title XIX.

	of referrals into Title XIX · Increase percentage of Medicaid eligibles enrolled in the program as demonstrated on CPS	· Tracking system under development · As of March 1999, there are 16,000 Medicaid eligibles enrolled as a result of NJ KidCare publicity, who would not otherwise, have been enrolled. This is based on a direct estimate from Medicaid eligibility, using comparisons with prior years growth, not from inferences from the CPS, and implies that there are two additional Medicaid eligibles for every three NJ KidCare eligibles enrolled.
Quality-Beneficiary Satisfaction with Care		
· Expand NJ participation in CAHPS demonstration to include all children covered under Title XXI	· Adjust statistically valid sample to include Title XXI population.	· Title XXI information will be available in year 2000.
Network Adequacy	x	x
· Ensure networks as reported by plans are actually available	· % of providers (FTEs) listed who are actually accepting new beneficiaries	· It is estimated that 90% of the primary care physicians are accepting new beneficiaries at any given time.
· Pediatric specialists	· Number of specialists who limit practice to pediatrics	· The HMO network has 1,194 Pediatricians, 1,070 Family Practitioners, 591 Specialists limited to Pediatrics.
· Mental Health Services	· A narrative description of the plans pediatric mental health provider network, including the number and type of MH providers specially trained to treat children and adolescents	· Mental health services are a managed care carve-out from the standard benefit package. Eighty-five mental health clinics have been identified as serving the NJ KidCare population.

· Dental Services	· A narrative description of the plans' dental provider network, including the number and type of dental providers specially trained to treat children · % primary care dentists (FTEs) · % pediatric dental specialists	· All of the HMOs' have contracts with primary care dentist and specialists including orthodontists, prosthodontists, endodontists, periodontists and oral surgeons. They are required to maintain a primary care dental ratio of 1 per 1500 members. · All of the HMO's have dentist available for pediatric members. · The dental network has 169 dental specialists.
Access to Services		
· Children's access to primary care providers	· % of Title XXI enrolled children by age category that had a visit with a health plan primary care provider during the reporting year or the year preceding reporting year	· These studies are conducted utilizing HEDIS protocols for data collection and review methods, HEDIS recommends that proper interpretation of the data to determine HMO performance requires a review of care over time and the minimum time period is 12 months of care under the HMO. Therefore, since the NJ KidCare program has not been in operation for 12 months, the data is not available for this reporting period.
Use of Service	x	x
· Well child visits in the first 15 months of life	· % of members who turned 15 months during the reporting year and who received either zero, one, two, three, four, five or six or more well-child visits with a primary care provider during the first 15 months of life	· Same as above.
· Well child visits in the third, fourth, fifth and sixth	· % of members who were 3, 4, 5, or 6 years old during the	· Same as above.

year of life	reporting year and who received one or more well-child visits with a primary care provider during the reporting year	
· Adolescent well care visits	· % of members who were age 12 through 18 years of age during the reporting year who have had at least one comprehensive well-care visits with a primary care provider during the reporting year	· Same as above.
Health Outcomes		
· Childhood immunization status	· % of children in plan who have received appropriate immunizations by their 2nd birthday	· These studies are conducted utilizing HEDIS protocols for data collection and review methods, HEDIS recommends that proper interpretation of the data to determine HMO performance requires a review of care over time and the minimum time period is 12 months of care under the HMO. Therefore, since the NJ KidCare program has not been in operation for 12 months, the data is not available for this reporting period.
· Adolescent immunization status	· % of 13 year olds in plan who received all appropriate immunizations by their 13th birthday	· Same as above.
· Lead Screening	· % of children in plan who have received appropriate lead screenings by their 6th birthday	· Same as above.

"Crowd-Out" Indicators

If a family were to drop employer or individual coverage they already have for their children in order to take advantage of state subsidized coverage, then the NJ KidCare program would result in a "crowd-out" of existing coverage. The purpose of the federal law was to provide health insurance coverage to uninsured children, not to replace existing coverage. In fact, the federal law requires states to include a description of the procedures to be used to insure that the insurance provided under the State Child Health Plan does not substitute for coverage under group health plans. In New Jersey, the look back period serves this purpose.

Initially, the look back period for NJ KidCare Plans B and C was set at 12 months. This mirrored the look back period used under the Health Access program, a State run program that provided health insurance for uninsured families. However, when NJ KidCare was implemented, the Department pledged to review this policy after the program was in place and, if feasible, reduce the look back period. The culmination of this review supports the premise that dropping the period of uninsurance from twelve to six months would not markedly increase the risk of "crowd-out" or increase program costs, since it is estimated that only 6,478 additional children would be eligible for the program.

The following chart, for the period, May 1998 through December 1998 represents families that submitted KidCare applications. The report captures children determined ineligible based on current health insurance and the existence of health insurance within the last 12 months.

Month	Current Health Insurance	Health Insurance In The Last Twelve Months
May 1998	15	9
June 1998	62	5
July 1998	45	21
August 1998	40	10
September 1998	37	1
October 1998	26	9
November 1998	46	4
December 1998	31	7

Total	**302**	**66**

Outreach Indicators

New Jersey has developed procedures that indicate successful outreach efforts for the NJ KidCare Program. These processes involved significant changes in procedures regarding applications, eligibility, outstationing of staff, marketing and publicity, private and public partnerships, and continuous eligibility.

Applications

- **Application simplification and reduction: The KidCare application was simplified using easy-to-understand language and a more attractive layout. A complicated ten-page application was reduced to an intact four-page application.**

- **Standardized documentation: By standardizing the documentation needed for the application process, applicants and intake staff clearly understand the information needed to expedite the completion of the application. An added benefit is a reduction in the number of incomplete applications.**

- **Mail-in applications: Face-to-face interviews were eliminated as part of the application process. This elimination allows working families to complete and mail-in the applications.**

- **Application requests: A report, generated weekly, indicates the number of applications requested. Key information is provided about KidCare applications requested but not submitted. A cross-referencing system allows for identification and follow-up. Follow-up activities include a four-question telephone survey to determine reasons for not completing the application. If warranted, assistance in completing the application occurs.**

Eligibility

- **Asset test requirements: For the NJ KidCare program, applicants are not required to report tangible property. This allows families who otherwise would not have qualified for the program an opportunity to become eligible. A key report, Households Determined Ineligible by Reason, identifies by reason, children who are determined ineligible, (i.e., insurance in the last twelve months, age over eighteen, or income greater than 200% of the poverty level). A key indicator from the report supports the critical need for focused KidCare education. KidCare focused education will be covered under the beneficiary education program.**

Outstationing of Staff

- **District offices, satellite and community enrollment sites: Staff were outstationed to ten (10) Medicaid district offices, three (3) satellite sites, and over four-hundred community enrollment sites to assist in outreach efforts. Staff outstationed at the offices and sites provided direct enrollment assistance.**

Marketing and Publicity

- **Media: As a result of planned media activities, the NJ KidCare receives over a 1,500 calls a week totaling 70,000 calls to date. These calls gauge the source of referrals (i.e., newspapers, schools or radio) see appendix. This allows the program to target the "best practice" for outreach. New Jersey's experience indicates that the newspaper and schools yield the best results.**

- **Media and Public Relations Campaign: NJ KidCare entered into contract with a media and public relations firm to increase its visibility through the use of marketing, media advertisement, and focus groups. The efforts resulted in a greater understanding of the more successful types of marketing and advertising materials required to increase enrollments. The use of posters depicting families were found to be productive in increasing enrollment as well as KidCare recognition.**

Development of private and public partnership

Committee structured input: NJ KidCare Forum, an advisory group, was convened during the implementation of KidCare. This forty-nine member forum, made of various private and public entities, provided key input for the program. The forum also provided a link to the development of new private and public partnerships.

- **Community enrollment sites: the State made a concerted effort to encourage community based organizations to partner with New Jersey to outreach and enroll children into the program. This effort provided for over 400 private and public partnerships.**

- **AmeriCorp VISTA site: NJ KidCare is particularly proud of its partnership with VISTA making it the first Child Health Insurance Program to do so in the nation. VISTA members have a major role in outreach efforts by identifying uninsured children from low income working families who may be eligible for the KidCare program. An attractive benefit of this partnership is that it is offered at no cost to the State. The costs for the services provided by VISTA members are assumed by AmeriCorp.**

- **Media contract: Through the media contract and its use of focus groups, a structure is in place that may provide for additional private and public partnerships. KidCare believes that partnerships can be developed through knowledge about the focus group participants and their associations with churches, community based organizations, and other entities.**

Continuous Eligibility

- **NJ KidCare eligibility: Once a beneficiary becomes eligible for NJ KidCare, eligibility is continuous for twelve months. A self-reporting mechanism allows for eligibility to continue or cease.**

Conclusion

The Children's Health Insurance Program (CHIP) has allowed the State of New Jersey to enrolled over 26,000 low income, uninsured children in it's NJ KidCare program. The success of this federal/state program can be linked to the commitment of the Governor of New Jersey, Christine Todd Whitman, the governor's cabinet and the Commissioner of the Department of Human Services.

In a one-year period, New Jersey has introduced and implemented three NJ KidCare plans, Plans A, B, and C. Plan A (Medicaid expansion) provides coverage for children up to 133% to the Federal Poverty Level (FPL). Plan B provides health care coverage for children up to 150% of the FPL and Plan C provides coverage for children up to 200% of the FPL. Recently, the Governor announced an expansion of NJ KidCare. NJ KidCare will be expanded to 350% of the FPL.

New Jersey's commitment to ensure the receipt of needed and deserving health care insurance to all eligible uninsured children is present in the design, development and implementation of NJ KidCare. NJ KidCare is a complement of enabling strategies with the overall goal to identify, enroll, and assist New Jersey's children obtain quality health care. The first year strategies included simplifying the administrative processes used in eligibility determinations, coordinating with community-based organizations to assist in the enrollment process, designing effective outreach activities that educate and enroll children, collaborating with private and public sector organizations and constituencies, and expanding existing infrastructure to accommodate NJ KidCare.

The expeditious implementation of NJ KidCare has provided a valuable blueprint for continued success in the provision of coverage for low income, uninsured children in New Jersey. This blueprint will be used as a framework in the second year of implementation to focus on strategies to address access to health insurance and access to care. Specifically, the focus on these two areas will accomplish the following goals: increase enrollment of the targeted population, assure quality of care through education and monitoring of performance standards, and monitor enrollment redeterminations to ensure that eligibility remain intact for eligibles.

In its first year, NJ KidCare enrolled 25 percent of its targeted population. NJ KidCare is prepared in its second year to reach a higher percentage of its targeted population by addressing the reasons eligible families do not enroll. It has been determined that 16,000 Medicaid eligibles, who otherwise would not have enrolled, enrolled as a result of NJ KidCare publicity. Positive and persistent NJ KidCare information can be attributed to the change in enrollment status.

To further examine reasons eligible families do not enroll, NJ KidCare will look and address three perceptions that serves as barriers to enrollment. The barriers are:

Public Charge: Immigrants are reluctant to obtain public benefits for their children for fear that its use will put them in jeopardy of being considered a "public charge," and affect their immigrant status. NJ KidCare will actively target these families and provide appropriate education so that they can receive quality health.

No need for health insurance: There are uninsured families that may question the need for NJ KidCare because their children are healthy. Through education, NJ KidCare will stressed the importance of having health insurance to maintain the health of their children by having preventive care in the form of diagnostic, screening exams, and immunization services.

Reluctance to accept "government" help: There are uninsured families that may be reluctance to accept "government" help. This barrier to enrollment was initially addressed by designing NJ KidCare to resemble a "private insurance model." NJ KidCare remains sensitive that this may still serve as a barrier to enrollment especially as Plan D is implemented which provides coverage up to 350% of the poverty level. NJ KidCare will continue to encourage participation by eligible families by building upon the "private insurance model," providing education, and examining other ways to help families overcome their reluctance to accept "government" help.

NJ KidCare is committed to assuring quality and appropriateness of care and access to services. Through the combined efforts of NJ KidCare and eligible families, appropriate performance measures will be monitored. Armed with the knowledge and experience gained in its first year, NJ KidCare is expected to exceed its initial success by focusing on, in the second year, enrollment driven activities. These activities include changes in the media campaign designed to provide motivation to families that will enable them to take responsibility for obtaining and accessing quality health care.

As the name implies, NJ KidCare cares about its children. This care extends from the outreach efforts through the enrollment process. Through education, and ongoing support, NJ KidCare will ensure that all families continue to participate in and benefit from the program for as long as they remain eligible. Additionally, in order to impact the health of children, NJ KidCare is committed to educating

families on the importance of preventive care, early intervention, and effective management of chronic condition, e.g., childhood asthma.

New Jersey is extremely fortunate to have been given the opportunity to provide health care to its children and takes seriously its responsibility to impact the health and well being of its future generation through NJ KidCare.